# *SECTION TWO: INTERVENTIONS*

# Preliminary Development of Trauma-Focused Treatment Groups for Incarcerated Juvenile Offenders

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**SUMMARY.** Most male juvenile offenders have been exposed to trauma. Many juvenile offenders have experienced both acute and chronic trauma. Trauma exposure among offenders is closely linked to their criminal behavior, yet few protocols have been developed to treat posttraumatic sequelae in a delinquent population. This article describes initial efforts to develop group therapy services for incarcerated male ju-

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[Haworth co-indexing entry note]: "Preliminary Development of Trauma-Focused Treatment Groups for Incarcerated Juvenile Offenders." McMackin, Robert A. et al. Co-published simultaneously in *Journal of Aggression, Maltreatment & Trauma* (The Haworth Maltreatment & Trauma Press, an imprint of The Haworth Press, Inc.) Vol. 6, No. 1 (#11), 2002, pp. 175-199; and: *Trauma and Juvenile Delinquency: Theory, Research, and Interventions* (ed: Ricky Greenwald) The Haworth Maltreatment & Trauma Press, an imprint of The Haworth Press, Inc., 2002, pp. 175-199. Single or multiple copies of this article are available for a fee from The Haworth Document Delivery Service [1-800-HAWORTH, 9:00 a.m. - 5:00 p.m. (EST). E-mail address: getinfo@haworthpressinc.com].

 

venile offenders who have histories of significant trauma exposure and current symptoms of PTSD. Four separate pilot groups were conducted in two Massachusetts Department of Youth Service secure residential facilities. The treatment included trauma psychoeducation (including the relationship between trauma and offending), therapeutic trauma exposure through discussion and expressive arts, and coping skill development. The treatment development and initial implementation as well as directions for future research are discussed. 

**KEYWORDS.** PTSD, delinquency, offending behavior, aggression, expressive therapy

An understanding of the relationship between trauma and delinquency has evolved over the past 60 years, with the emphasis moving from the impact of trauma on intrapsychic development to its effect on personality, beliefs, and behavior. Aichhorn (1935) first noted that trauma contributed to delinquents' failure to successfully negotiate early developmental stages (Erikson, 1950; Menninger, 1966) and led to severe deficits in ego and superego development (Loewald, 1962; Novey, 1955). In the 1960s and 1970s, empirical research documented the relationship between life experiences and subsequent behavior. Minuchin and Guerny (1967) stated that "a multitude of children in the institutions and slums of our big cities share with each other a style of thinking, coping, communicating and behaving, aspects of which can be directly traced to the structure and processes of the family system of which they are a part" (p. 193).

More recently, Garbarino, Dubrow, Kostelny, and Pardo (1992) compared the impact of living in a violent urban environment to growing up in a war zone. Exposure to such acute and chronic danger "imposes a requirement for developmental adjustment–accommodations that are likely to include persistent PTSD" (Garbarino, Kostelny, & Dubrow, 1991, p. 377). Many juveniles grow up in familial and community "war zones," which shape their personality structure, cognitive beliefs, and behavior.

In this article, we present our initial attempts to integrate the treatment of trauma-associated emotional, psychological, and behavioral sequelae into two residential juvenile offender treatment programs. We

present rationale for the treatment approach, initial group interventions, and then report on the feedback and modifications to the treatment model. Finally, we make recommendations for further development of this intervention.

## *TRAUMA AND DELINQUENCY*

Over the past ten years, studies have documented high rates of trauma exposure among juvenile offenders, with many youths experiencing numerous traumatic events. These events include (a) experiencing childhood physical and/or sexual abuse; (b) experiencing serious life threats and/or injuries; (c) witnessing severe injury and/or death of another, and (d) being involved in gang violence (Burton, Foy, Bwanausi, Johnson, & Moore, 1994; Cauffman, Feldman, Waterman, & Steiner, 1998; McMackin, Morrissey, Newman, Erwin, & Daly, 1998; Smith & Thornberry, 1995; Steiner, Garcia, & Matthews, 1997; Weeks & Widom, 1998; Widom, 1995). The typical juvenile offender, in the brief span of his or her life, has been exposed to numerous potentially traumatic events. Such exposure may lead to the development of posttraumatic stress disorder (PTSD), an often chronic and debilitating psychological disorder characterized by intrusive memories of the trauma, increased avoidance and interpersonal difficulties, and increased physiological arousal (American Psychiatric Association, 1994).

Development of PTSD is predicted by (a) presence of previous psychological problems (i.e., depression, anxiety, and substance abuse) and life stress (Breslau, Davis, Andreski, & Peterson, 1991; Burgess, Hartman, & McCormack, 1987; Kiser, Heston, Millsap & Pruitt, 1991); (b) prior trauma history (Pelcovitz, Kaplan, Goldenberg, Mandel, Lehane, & Guarrera, 1994); (c) severity of the trauma (e.g., March, 1993); and (d) perceived life threat during and after the traumatic event (e.g., Kilpatrick & Resnick, 1993; Kilpatrick, Saunders, Amick-McMullan, Best, Veronen, & Resnick, 1989; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). Studies indicate that 25%-30% of individuals exposed to traumatic events subsequently develop PTSD (Carlson, 1997).

Protective factors that mitigate against the development of PTSD are a well-developed sense of self (van der Kolk, 1987) and strong family/community support (Galante & Foa, 1986; McFarland, 1987). The severity and number of trauma exposures identified in a delinquent population, combined with their psychological and developmental vulnerabilities, and their lack of protective factors, place delinquent youth at

high risk for developing PTSD. In the few studies of PTSD in juvenile offender populations, rates of a current PTSD diagnosis range from 24% to 51% among males juvenile offenders (Berton & Stabb, 1996; Burton et al., 1994; McMackin et al., 1998; Nadel, Spellman, Alvarez-Canino, Lausell-Bryant, & Landsberg, 1996) and 49% among female juvenile offenders (Cauffman et al., 1998).

The Justice Department recognizes the association of a history of trauma with subsequent violent behavior. In *Combating Violence and Delinquency: The National Juvenile Justice Action Plan* (Coordinating Council on Juvenile Justice and Delinquency Prevention, 1996), Objective 5 is to "Break the cycle of violence by addressing youth victimization, abuse and neglect" (p. 9). Novaco and Chemtob (1998) describe this cycle of violence in relation to trauma and PTSD:

> Anger regulation is affected by traumatic experience, which resets activation and inhibition patterns in accordance with perceived threat, and by the shift into "survival mode" functioning. Patients with PTSD readily shift into "survival mode," and, as a part of the peremptoriness of that shift, there is a substantial loss of self-monitoring .... High-intensity anger combined with diminished inhibitory control is alarming and worrisome. (p. 171)

For youths, this relationship between arousal and anger may have long-lasting developmental effects on styles of interaction, with the propensity for violence becoming a lifelong behavior trait (Cicchetti & Toth, 1995; Davis & Boster, 1992; Patterson, DeBaryshe, & Ramsey, 1989). Cicchetti and Toth (1995) found that rather than habituating to further aggression, abused and neglected children appear to be sensitized to it. Specifically, traumatized children become more aroused and angered by witnessing conflict and report greater distress and fear (Cummings, Hennessey, Rabideau, & Cicchetti, 1994; Hennessey, Rabideau, Cicchetti, & Cummings, 1994). Hypervigilance and arousal may lead to the development of aggressive patterns, particularly if home conflict is chronic (Lewis, 1992). To break the lifelong and potentially intergenerational cycle of violence, interventions to counter the effects of trauma exposure among juvenile offenders is necessary.

## *JUVENILE OFFENDER TREATMENT*

The treatment of delinquency has become more focal and structured over the past twenty years. Current juvenile justice interventions are

outcome-driven and fit within the Justice Department's concept of "Restorative Justice" where "the offender leaves the criminal justice system more capable than when s/he entered" (Carey, 1997). A primary focus in juvenile offender treatment is to reduce the offender's "risk factors" for future delinquent behavior, while enhancing "protective factors" that will help the offender make a successful community adjustment (Office of Juvenile Justice and Delinquency Prevention, 1997). Risk factors often associated with delinquent behavior include school problems, substance abuse, young age at first offense, intellectual factors, family dysfunction, parental substance abuse, family criminal involvement, poverty, and organic problems (Zigler, Taussig, & Black, 1992).

Outcome studies that compared the efficacy of different juvenile offender treatment approaches found that cognitive-behavioral approaches were more effective at reducing recidivism than were nondirective or psychodynamic approaches (Andrews & Bonta, 1994; Gendreau & Ross, 1981; Goldstein, 1988). The recognized effectiveness of cognitive-behavioral treatment with offenders has given rise to numerous intervention programs designed specifically for delinquent youth (Carey, 1997; Dryfoos, 1991; Tate, Reppucci, & Mulvey, 1995). Currently, protocols are available for juvenile offender treatment programs aimed at social skill development (Bazemore & Terry, 1997), aggression management (Goldstein, 1988), substance abuse (Gorski, 1993), and sexual offending (Laws, 1989). Most of the current cognitive-behavioral interventions emphasize that delinquents must learn about and take responsibility for their behavior as well as develop alternatives to maladaptive behavior and beliefs (Bazemore & Terry, 1997; Carey, 1997). Mastery, competency, and related improvements in self-esteem, along with family and community involvement, are stressed (Dryfoos, 1991; Goldstein, 1988). Due to the high prevalence of language deficits among juvenile offenders (Andrew, 1974; Stattin & Klackenberg-Larsson, 1993; Walsh, 1992), non-verbal techniques such as role-playing and expressive arts are integrated into many intervention programs.

Juvenile justice professionals are sensitive to not providing excuses to offenders for their behavior. George and Marlatt (1989) described this concern with respect to sex offender treatment:

> [In the] acknowledgment of oneself as addict and admission of powerlessness, the sexual-addiction approach places the locus of responsibility for the offense pattern and for treatment outside the offender. Such an externalization of blame and treatment respon-

> sibility can backfire with offenders who are already reluctant to take any responsibility for their misdeeds and choose to view this so-called addiction as a convenient excuse before and after a reoffense. (p. 12)

The concept that an individual is accountable for his or her actions is central to offender treatment. The desire to avoid providing offenders with an excuse or rationalization for criminal behavior may have delayed recognition of the need to treat trauma exposure in this population.

Many delinquency interventions use a "Relapse Prevention" or "Offense Cycle" treatment approach to help offenders learn about and gain control over their criminal acting-out. Most relapse prevention (RP) models of treatment utilize a behavior cycle. The behavior cycle is a sequence of emotions, cognitions, and behaviors that if unchecked can create a self-reinforcing, and at times, addictive, pattern of offending behavior. For sex offenders, the cycle may be referred to as the offender's "Deviant" or "Offender Cycle" (Longo-Freeman & Bay, 1988), whereas the cycle may be referred to as the youth's "Angry Behavior Cycle" in treatment of aggression (Goldstein, 1988). Gray and Pithers (1993) describe the sex-offense cycle as "a direct sequence of offense precursors." They outline the sequence as: "Unpleasant Affect -> Deviant Fantasy -> Passive Planning -> Cognitive Distortion -> Disinhibition -> Deviant Act" (p. 297).

The idea of a trigger or an offense precursor is central to all RP models of treatment. The offense trigger can initiate or move an offender into his or her cycle. All interventions strive to have the offender "intervene in or break into his offense pattern at its very first sign" (Knopp, 1984), recognizing that the deeper an offender goes into the thoughts, fantasies, and behaviors of a cycle, the more difficult it is to break.

That trauma-associated affects may become offense triggers makes theoretical sense considering the high rate of trauma exposure among sex-offenders, yet only one empirical study has been done to link trauma-associated affects and PTSD to offense triggers. McMackin, Leisen, Cusack, LaFratta, and Litwin (2001) interviewed treating clinicians to examine the link between trauma-associated sequelae and offender triggers among juvenile sex-offenders. In a sample of 40 juvenile sex-offenders treated with an RP model for at least six months, McMackin et al. found that offense triggers were related to an intense trauma-associated feeling of fear in 37.5% of the sample, horror in 20%, and helplessness in 55% of the sample.

## *TRAUMA TREATMENT*

Most treatment protocols for PTSD and trauma exposure were developed for adults and children rather than for adolescents. Effective approaches to treating trauma-related psychological difficulties have traditionally been divided into two broad categories: skills training and therapeutic exposure.

Skills training approaches include a number of interventions aimed at improving an individual's ability to cope with and manage emotional reactions (e.g., anxiety) related to their traumatic memories (e.g., Foa, Rothbaum, Riggs, & Murdock, 1991; Kilpatrick, Veronen, & Resick, 1979). However, as conceptualizations of post-traumatic reactions expanded to incorporate a wider variety of emotional reactions, such as anger, sadness, and guilt, cognitive and behavioral techniques to cope with these feelings were incorporated into treatment approaches (Kimble, Riggs, & Keane, 1998). Typically, skills training programs include relaxation techniques, role-playing, self-talk, and cognitive restructuring. Focused interventions aimed at specific issues such as communication and assertiveness difficulties, social skills problems, and violence may also be included (Kimble et al., 1998). In general, such skills-based programs have proven successful in reducing trauma-related distress among adults (Foa et al., 1991; Kilpatrick, Veronen, & Resick, 1979).

The other effective approach to treating post-trauma reactions is the use of direct therapeutic exposure (e.g., desensitization, flooding, prolonged exposure), which has proved effective with adult rape survivors (Foa et al., 1991) and combat veterans (Boudewyns, Hyer, Woods, Harrison, & McCraine, 1990; Keane, Fairbank, Caddell, & Zimering, 1989). More recently, exposure-based treatments for PTSD have been found effective with children and adolescents (March, Amaya-Jackson, Murry, & Schulte, 1998; Saigh, 1992). Therapeutic exposure requires the client to directly confront traumatic cues and memories within a supportive individual or group therapy environment. Typically, clients are asked to relate the events of their trauma to the group (or individual therapist) verbally or in writing. In conjunction with these exercises, the client is encouraged to generate a mental image of the events that includes as much sensory information as possible. To optimize the effectiveness of exposure-based interventions, it is suggested that clients reexperience the intense emotions associated with the memories, as well as relating the actual events of the trauma (Foa & Kozak, 1986). Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro,

1995) is another validated treatment for PTSD (Chemtob, Tolin, van der Kolk, & Pitman, 1999), which is of less interest to us because it cannot be adapted to a group format. Although the underlying mechanisms of EMDR have yet to be fully understood (e.g., Chemtob et al., 1999), it is a hybrid method that includes many of the components common to effective cognitive-behavioral approaches (Hyer & Brandsma, 1997; Sweet, 1995).

Four common themes occur across the various adult and child trauma treatment approaches (Gil, 1991; Greenwald, 2000; Lubin & Johnson, 1997; Pynos & Eth, 1986; Saigh, 1992):

1. Creating a safe treatment environment;
2. Providing education about trauma and its effects;
3. Desensitizing clients to traumatic material through discussion, habituation, or exposure to the traumatic stimuli; and
4. Developing and/or strengthening coping skills to manage trauma-associated sequelae.

Many PTSD treatment protocols can be adapted for use in individual or group therapy. Treatment programs vary in their degree of emphasis on skills training and/or exposure. All treatment protocols require, first, establishing a safe treatment environment. Generally adolescent participants receive educational material regarding trauma and its impact in the early stage of treatment, while trust is being established. The educational material provides a common language and understanding of trauma that can then be integrated throughout the treatment. Most trauma treatment programs for children tailor the educational material to the child's level of cognitive development and may include the use of non-verbally based techniques to access traumatic material (Gil, 1991). The four themes outlined above are not sequential steps in trauma treatment. For example, the development, maintenance, and deepening of a safe, trusting treatment environment may be emphasized initially but would remain a theme throughout the course of treatment.

## *FIRST INTERVENTION TRIAL*

*Overview.* Within Massachusetts Department of Youth Service (DYS) residential programs there has been an increased awareness of the extensive trauma exposure and PTSD symptomatology among juvenile offenders. This awareness has led to collaboration between the first au-

thor and staff at the National Center for Posttraumatic Stress Disorder (NC-PTSD) at the Boston VA Medical Center. The trauma treatment groups described below were a pilot project that grew out of earlier research on the relationship between trauma exposure and delinquency conducted by the first author and NC-PTSD staff (McMackin et al., 1998; Erwin, Newman, McMackin, Morrissey, & Kaloupek, 2000). We will report on the early development of trauma-focused group therapy services within two residential programs for delinquent youth.

Cognitive-behavioral and milieu group therapy are the primary treatment modalities used within the Massachusetts DYS system at each of their juvenile justice facilities. The juvenile justice literature has stressed the effectiveness of cognitive-behavioral group treatment over individual therapy with respect to the acquisition of skills that would allow an offender to succeed in the community and not recidivate (Bazemore & Terry, 1997; Carey, 1997). A group intervention was selected to address trauma associated sequelae in juvenile offenders in order to be consistent with existing services at each site and to draw on established PTSD group treatment protocols (i.e., skills building and therapeutic exposure).

The first set of groups was patterned partly on outpatient psychoeducational groups offered at the Boston VA PTSD Outpatient Clinic and NC-PTSD (Monroe & Bitman, 1997). These were 10-12-session, cognitive-behavioral groups for male PTSD combat veterans that included psychoeducation and limited controlled exposure. An NC-PTSD psychologist provided ongoing consultation to the juvenile offender group leaders. The group leaders drew on their collective experience in the treatment of juvenile offenders, the VA group format, and trauma and juvenile justice treatment literature to develop the initial program. Because this was a new intervention strategy, the primary objectives of the first groups were to become familiar with and modify group procedures.

The overall treatment goal was to give the participants a better understanding of how trauma affects their lives and to help members develop socially acceptable coping skills to manage the effects of trauma. The treatment protocol was based on cognitive-behavioral principles, and utilized psychoeducation, controlled exposure, skills development, and expressive arts. Group members were given psychoeducation about the nature of trauma and PTSD. Expressive arts and controlled exposure were used to access and discuss traumatic material. Members also learned skills to manage their arousal and emotions. All group members had previously participated in cognitive- and behaviorally-based treatment groups for aggressive behavior, substance abuse, or other offense related behaviors while in the facility.

*Intervention Sites.* Groups were conducted in two Massachusetts DYS residential centers, the Connelly Treatment Unit (CTU) and the Pilgrim Center (PC). CTU is a 16-bed, secure facility serving juvenile offenders from the metro Boston area. CTU represents the most secure type of facility in Massachusetts. Youths range in age from 13 to 21 years, and are committed for property and person crimes, excluding rape, indecent assault and battery, and murder. The treatment program at CTU is a mix of individual therapy and group therapy, as well as family therapy whenever possible. The average length of stay is six months, and youths return to their homes or to a residential placement after leaving CTU.

PC is a residential, 24-bed facility located in a suburb of Boston. PC is considered a medium staff-secure facility, meaning there is no fence or wall around the perimeter and doors are unlocked to allow free movement within the program. Many residents placed at PC have been stepped-down after a stay in a higher security facility. Youth range in age from 13 to 18 years, and are committed for property and person crimes, including rape, and indecent assault and battery. The treatment program is a mix of individual and group therapy, family therapy, sex offender treatment, and other offense-specific treatment. PC is an "open" program, meaning all offenders and staff are aware of the offense of each resident, although they are not necessarily aware of the details of the offense. The average length of stay is 15 months for sex offenders and nine months for other offenders. Youths return to their homes or to independent living situations after completing the PC program.

The primary treatment orientation at both CTU and PC is cognitive-behavioral group treatment. Juvenile offenders in treatment at both CTU and PC are expected to examine beliefs that underpin their criminal behaviors and place them at risk for future criminal acts. They have opportunities to learn and practice new behaviors, such as how to manage disagreements without resorting to violence, both within treatment and in the program milieu. The trauma treatment groups were provided as part of each youth's CTU or PC treatment plan.

*Participant Assessment and Selection.* All residents at both facilities were screened for trauma exposure and PTSD symptoms. Screening instruments included an adapted Richters' (1990) Exposure to Community Violence (CETV) scale and the Child PTSD Checklist (Amaya-Jackson, McCarthy, Newman, & Cherney, 1995). On the CETV, youths were asked to endorse the frequency of exposure to community violence (e.g., witnessing a shooting or life threat). On the Child PTSD Checklist, youths were asked to write three things they

found "very scary or frightening," and then to answer questions about PTSD symptoms related to the identified events. PTSD diagnoses were determined via symptom endorsement on the Child PTSD Checklist.

The CETV and PTSD checklist responses of each youth were reviewed with the youth's individual therapist, and referral to the group was discussed. Youths who endorsed at least one reexperiencing item and at least one other symptom of PTSD were interviewed for possible participation. Traumatic events and posttraumatic symptoms were reviewed, and youths were told that the group was for residents who had been exposed to a significant traumatic event and who were still affected by the trauma. Although they were told that the group was voluntary, group members understood that their participation would earn them points toward facility privileges.

Youths were told that they would learn about the effects of trauma and would be expected to explore and discuss their traumatic experience. They were told that it would be their decision as to how much detail they provided about their experiences. Five individuals were selected for the first PC group and six for the first CTU group. All group members met full current PTSD diagnostic criteria as measured by the Child PTSD checklist.

The initial groups were eight weeks long. The CTU group was co-led by a social worker and an art therapist. The PC group was co-led by a social worker and a psychologist (third and first authors). A childcare staff attended the CTU group but not the PC group. The CTU childcare staff person was a participant observer and monitored security. At both PC and CTU it is a unit practice for childcare staff to actively participate in the treatment program, including attending and leading some groups. The group leaders met biweekly with the consulting psychologist from the Boston VA Medical Center and with each group member's individual therapist.

*Goals.* The initial goal (Phase 1) was to create a safe, trusting group environment, while also educating the members about trauma exposure and possible symptoms. The trauma education gave group members a frame of reference through which they could understand their own experience and share it with others. The goal of Phase 2 was for members to participate in a self-paced controlled exposure experience to begin processing their traumatic experience. This was done through an expressive arts project that represented the member's personal trauma experience, and the projects were shared with the group. Special attention was focused on trauma-related feelings of fear and helplessness, as these were strongly endorsed on the screening measures. The goal of

Phase 3 was for each participant to learn a coping skill to manage trauma-related stress. Muscle relaxation, breathing techniques, and use of music were selected since these are easily learned and have been proven effective to manage anger (Novaco & Chemtob, 1998). It was expected Phase 1 would be two weeks, Phase 2, four weeks, and Phase 3, two weeks.

*Procedures.* Each group session was 75 minutes in length and followed the same format. The session began with a "check-in" to help group members focus on the group tasks and acknowledge issues or conflicts within the group or residence. The check-in assisted in establishing a safe treatment environment where all members acknowledged the shared purpose of the group. As part of the check-in the group leaders presented the topics, goals, and activities for the session. Each session included either an expressive arts project or a discussion of an earlier project. The group concluded with a "check-out," during which each group member reviewed his experience in the session and acknowledged any conflicts or issues that arose. Group leaders met regularly with members' individual therapists and also contacted them with additional concerns when necessary.

*Phase 1.* In the first sessions of Phase 1, group members described their understanding of trauma and collectively developed a definition of trauma. They also made collages of traumatic events taken from the newspaper and magazines and then discussed their collages. They provided members with explanations to clarify misconceptions they held regarding trauma and PTSD. Members were shown video clips from movies and then discussed the role of trauma in the movie from the perspective of individual characters. Group members also made drawings and small sculptures to depict feelings of helplessness and extreme fear. Finally, members drew faces expressing different feelings. They then listened to various types of music to find themes of trauma, which they then associated with the faces. The faces were subsequently used as props by all group members for the remainder of the group to explain feelings associated with traumatic experiences.

During Phase 1, many youth spontaneously spoke of their traumatic experiences. Members were discouraged from detailed discussion of their personal experiences, since it was not known if group cohesion and safety were adequately established. Treatment issues were discussed with the primary therapist as needed.

*Phase 2.* During Phase 2, members worked on two expressive arts projects. In the PC group, members constructed "self-boxes," which

were cardboard boxes with a lid. Group members were told that the exterior of the boxes represented themselves, including their traumatic experience. The interior represented how the trauma affected them internally. In the CTU group, members constructed free-form sculptures that represented their trauma-associated feelings. Participants worked on their projects individually or in small groups over two sessions. While the residents were working on projects, group leaders worked individually with members discussing what the projects represented and sharing ideas. Participants shared their projects with the group over two sessions.

*Phase 3.* The first two phases of the groups took longer than expected because the discussion of the youths' art projects and personal trauma experiences required more time than initially anticipated. Only one relaxation training session of a controlled breathing technique was conducted.

*Discussion of First Group Intervention.* All youths were interviewed for feedback after the final session. A number of group members said during the first two group sessions that they felt "tricked" into the group. They stated that, although they took the self-report measures along with all other PC and CTU residents, they believed they were unfairly chosen to participate in the group. Youths were reminded during the first two group sessions that they were selected for participation based on their trauma histories and current trauma-related problems. All youths accepted this explanation by the third group session. All group members lived together in the therapeutic milieu and participated in other treatment groups together. Their initial concerns about being "tricked" into the group were viewed by the leaders as related to the development of group trust and an initial resistance that is often present at the beginning of any group in a juvenile justice setting. It is our interpretation that explanations provided by the leaders and the participants' familiarity with each other helped group members get past their initial resistance to establish group trust. At PC the initial resistance was somewhat complicated by having the group scheduled in what had previously been free time.

During post-group interviews, the majority of participants said that the most helpful part of the group was "when everyone sat down and talked about certain events which happened in their lives that still hurt them." Similarly, the most frequently stated benefit of the group was members' ability to talk about their traumatic experiences. Several times, a youth's trauma experience was directly expressed or acted out symbolically in the group. In one PC session, when individuals dis-

cussed their pictures of helplessness, three boys put tape over their mouths, eyes, and ears. In a criminal justice setting, there is a temptation to sanction such behavior with some form of discipline, such as not awarding group participation points. In this case, however, such behavior was discussed as a strategy to cope with the stress of listening to another's experience of helplessness, or having to discuss one's own, rather than as a disciplinary problem. Group members reported that this discussion helped them to understand how their traumatic experiences could be expressed in their daily life. In the CTU group, the childcare staff was able to introduce material regarding a participant's behavior in the milieu, particularly social isolation and aggressive posturing that was then discussed as possibly related to prior trauma exposure.

Participants stated that the educational material assisted them in developing a common understanding regarding trauma, its impact and relationship to their criminal behavior. All PC group members participated in a relapse prevention model of treatment for either sex offending or substance abuse treatment. These youth applied their understanding of trauma to their offense cycle in relation to substance abuse and violence by recognizing that while in the community they used substance abuse and violence as means to deal with unpleasant affects associated with earlier trauma. Many members of the CTU group, although not in RP therapy, understood the connection between their violent behavior, substance abuse, and trauma history. Ongoing communication between group leaders and individual therapists appeared to facilitate exploration of trauma issues in and outside of the group context.

Both groups included individuals who had experienced multiple traumas, including sexual victimization and other violent trauma. During the controlled exposure phase, many youths spoke of life threatening situations, severe physical abuse, and violent losses, but no one openly acknowledged sexual victimization. Even in their symbolic representations of their traumatic experiences, group members appeared reluctant to express themes of sexual victimization; their art projects primarily focused on family and community physical violence. Youths spoke directly about violent situations they had experienced, such as shootings, but only indirectly referred to sexual victimization experiences with phrases such as "bad things that happened to me." The group leaders allowed members to proceed at their own pace with respect to describing their traumatic experiences.

All group members said they understood the purpose of the expressive arts projects, although they indicated that they should have had a range of projects from which to select. Most group members and all

group leaders saw eight weeks as too short a time period. At the exit interview, all but one member acknowledged the major impact that trauma had had on their lives, yet no participants thought they had PTSD. Due to time constraints, particularly the amount of time it took participants to discuss their large art projects, the Phase 3 goal of learning a coping skill was not achieved for any participants. Part of the last session was devoted to a controlled breathing exercise but participants did not get to practice this technique in other sessions.

## *SECOND INTERVENTION TRIAL*

*Overview.* Based on the feedback from members and leaders of the first group, the format of the second groups was modified. The number of sessions was extended to 10 weeks at CTU and 12 weeks at PC. The PC group remained co-led by the same two therapists and in the CTU group the social worker was replaced by the PC psychologist group leader. A childcare staff member was added to the PC group since having had such a staff member in the CTU group provided feedback from the milieu on daily behavior, particularly withdrawal or aggression that may be associated with trauma exposure. As with the first groups, screening instruments were administered during youths' facility intakes. The groups were held at a pre-established group time to minimize resistance. A group pre-test was added to measure understanding of and beliefs about trauma and PTSD. Group members were given several options for the controlled exposure project to allow for more individual expression of their trauma experience. The group phases and goals remained the same and will be discussed in more detail below.

A relapse prevention component was added to the PC group because all PC group members participated in RP therapy, and all group members from the first intervention trial, particularly the sex offenders, identified the connection between trauma exposure and offending behavior. The group leaders believed that, due to PC group members' familiarity with RP language and therapy, a relapse prevention-based trauma cycle would help them apply the educational material to their personal experience. An RP trauma cycle was developed for the PC group. Stages of the trauma cycle included: Trauma -> Reaction -> Action -> Symptoms -> Coping -> Feeling Okay. The first stage is the traumatic event or a re-experiencing of that event. The Reaction stage is the individual's immediate response to the traumatic event, while the Action stage is what the person does after the event. The next stage involves Symptoms asso-

ciated with the trauma. Coping, the final stage, represents how an individual attempts to decrease internal distress and arousal to feel Okay again.

*Procedures*. Thirteen youths participated in the second group cycle, six at PC and seven at CTU. All youths had significant trauma exposure with at least one re-experiencing symptom, and one or more additional symptoms of PTSD. Eleven youth met full criteria for a diagnosis of PTSD based on the Child PTSD checklist (Amaya-Jackson et al., 1995). Pre-test results showed that members had a poor understanding of trauma and its effects, and did not believe trauma treatment would be beneficial. The majority felt they received some support from their families, and recognized that others had similar experiences.

Unexpected negative factors affected the second cycle of groups. At CTU, major staff changes resulted in having only one on-site therapist available for the group leaders to speak with regarding group members. At PC, one group leader missed four group sessions due to a family member's illness. Space constraints resulted in the CTU group being held in a room less than half the size of the room used for the PC group.

*Phase 1*. Several components were added to Phase 1. First, a "trust fall" exercise, where members allow themselves to relax and fall back into the arms of another group member, was used in the first session of the PC group. The "trust fall" was to facilitate the development of trust and safety so group members could have more ownership of the group rather then feeling "tricked" into it. Second, relaxation techniques were introduced in the first PC group session and practiced in each subsequent session to allow time for skill acquisition. Both diaphragmatic breathing and deepening relaxation procedures were used to help members achieve a relaxed state. Finally, at PC, the trauma cycle was presented to help integrate the trauma treatment into each member's overall treatment plan.

*Phase 2*. The PC group members were presented with a range of art supplies from which to create the large expressive arts project. Projects included collages, "self-boxes," writing rap songs, and drawings. The confined space of the office used at CTU did not allow for each group member to complete a large expressive arts project. A number of smaller, alternative expressive arts projects were utilized. These projects included drawings that were representative of members' traumatic experiences, making small multimedia sculptures, and listening to and discussing music.

*Phase 3*. In Phase 3, situations from movie segments were discussed to understand adaptive and maladaptive trauma coping skills. In addi-

tion, participants examined how they used self-destructive means, particularly substance abuse and violence, to manage the emotions trauma evoked in them. In the PC group, the cycle of trauma was discussed with emphasis on how it related to coping skills and each member's offender cycle. As noted, relaxation procedures were introduced in the first PC session and practiced in each subsequent session. The final session of both groups was used for a review of the group.

*Discussion of Second Group Intervention.* The second series of groups provided a striking contrast to the first series, with the PC group proceeding as planned, and the CTU group progressing in a more haphazard manner due to staffing and space constraints. Prior to the beginning of the second CTU group, the unit's clinical director, who co-led the first group, and a second clinician left the program. The unit was left with minimal clinical support, forcing childcare staff to assist with clinical services. The staffing situation did not allow for ongoing communication with each member's therapist since many members did not have an individual therapist, and the trauma treatment was never integrated into each youth's overall treatment plan. Group leaders were consultants who did not have official staff status on the unit. As such, they had less authority in redirecting disruptive behavior through the loss of daily program points. Additionally, the reduction of clinical staff contributed to a general decline in the therapeutic milieu.

The second CTU group was held in a small office, less than half the size of the classroom where the second PC group was held. CTU group members were not able to work alone or in small groups on projects as was possible in the PC group. With seven group members, two leaders and one childcare staff, the CTU group members were frequently in each other's way. The safe milieu, considered essential for treatment of trauma, was not adequately established. In contrast, the large open space available for the PC groups enhanced development of the safe, trusting milieu by providing areas for the group to work as a whole or in smaller subgroups.

Even with these constraints, all of the CTU group members participated and explored their trauma histories directly and symbolically. Group members were loud and disruptive at times, but were never disrespectful to members who spoke of their personal trauma experiences. While there can be a tendency for juvenile offenders to tell "war stories," where past exploits are told in a glamorous or provocative way, the stories told in the group were shared within an atmosphere of support and seriousness. Members examined their maladaptive coping strategies and discussed alternative behaviors. They did not receive relaxation training due to the size of the room.

In the PC group, trust was rapidly established. Holding the group at an established group time and providing a clear explanation that the youth was selected for the group due to his prior trauma experience helped avoid members saying they were "tricked" into the group. Additionally, the "trust fall"exercise appeared to help facilitate trust. All group members understood the relapse prevention model, and familiarity with RP terminology appeared to help them discuss trauma and its relationship to their offense cycle in group and individual therapy. The integration of the relaxation protocol across sessions worked well. All group members developed some mastery of the relaxation techniques, and two reported they used it successfully to assist them with sleep disorders that predated the group. All group participants had individual therapists who were consulted weekly.

The feedback from group participants in the CTU group was mixed, while it was uniformly positive from PC group members. All group members viewed the sharing of traumatic life experiences and listening to others as the most important component. Two members of the CTU group and all members of the PC group expressed a desire for the groups to continue. Many members of the CTU group saw some of the expressive arts projects as "dumb." Overall, CTU group members took a more passive approach to the group than members of the PC group; for example, CTU members wanted to watch a video rather than work on an art project.

Clinician feedback was only available for the PC group. Each member's individual therapist indicated that the group and each youth's trauma history were discussed in individual therapy. Clinicians felt participants had improved their understanding of how trauma-associated feelings related to their offending. The relationship of trauma-associated affects of fear and helplessness to subsequent violence and substance abuse was addressed in group members' individual work and other treatment groups to help lower a youth's "risk" for future offending.

## *RESULTS*

Members of both the first and second group cycles reported an increased understanding of the ways trauma had impacted on them. Most members acknowledged how they used violence and substance abuse as ways to manage trauma-associated stress at different times in their lives. Participants' individual therapists reported trauma themes emerged more often in individual treatment than prior to the group. Participants familiar

with Relapse Prevention therapy reported the trauma cycle helped them see the connection between trauma exposure and aggressive behavior. Members of the second PC group that were able to practice relaxation procedures for 12 weeks reported improved coping skills including improved sleeping patterns and a better ability to manage anger.

A composite case example will help illustrate how the trauma treatment group was integrated into and impacted on the overall treatment plan for a youth.

### *Case Example: Lonny*

Lonny was a 17-year-old boy who was placed at PC after spending one year in a secure treatment setting.

Lonny's parents separated when he was five years old. Both parents were alcoholics, neglectful, and showed minimal interest in Lonny's education. Lonny had experienced school problems, mainly peer aggression, starting in the first grade. Lonny stated he "loved" to fight, both to hit and be hit by others. By the third grade he was placed in a class for students with behavior problems. When he first entered DYS secure treatment, his academic performance was over three grades below age level in all subjects. Lonny's mother and maternal grandmother raised him until age 10, when his mother died in a car accident. After his mother's death, he was raised by his grandmother and had periodic contact with his father. At eight years of age, Lonny had been sexually molested and anally raped at least five times by his mother's boyfriend. Lonny began to drink by age nine, smoked marijuana by age 10, and began taking sedating drugs regularly in his early teens.

At age 15, Lonny was convicted of indecent assault and battery, reduced from rape charges. Lonny and two friends had gang-raped a 13-year-old girl at a party. Initially, Lonny insisted the rape was consensual. He participated in over two years of sex offender relapse prevention treatment at PC and in secure treatment. After eight months of treatment, he acknowledged his involvement in the rape. Within RP offender-based treatment, Lonny had discussed his offenses in detail, as well as his history of abuse. He had identified substance abuse and anger as offense precursors or triggers.

At trauma group intake, Lonny identified the rapes and being shot at as significant traumatic events. He reported intrusive thoughts related to both events, as well as other associated symptoms of PTSD. During the trauma group, Lonny discussed the violence in his family and a serious threat to his life, but only indirectly referred to his history of sexual

abuse. Lonny's individual therapist reported that the sexual abuse was being discussed both in individual therapy and sex offender group.

Lonny understood that there was an association between his trauma history and offending behavior, but he did not fully appreciate the depth of that connection until he participated in the trauma group. The ongoing communication between Lonny's group therapist and his individual therapist facilitated a closer examination of the relationship between Lonny's trauma history and his offending behavior. In trauma group Lonny recognized that his experience of trauma-related helplessness contributed to his anger response and substance abuse. He used relaxation procedures to better manage his anger. In RP sex-offender therapy Lonny addressed the direct link between trauma-associated feelings of helplessness with anger and his risk of sexually acting out.

Lonny's understanding of the close association of trauma-associated affects, particularly helplessness, to anger and substance abuse was seen among many participants in all groups. The ability for a youth to focus on this in treatment was best done at PC based on the reports of individual therapists. It is the belief of the group leaders that the common relapse prevention language shared by all PC group members helped the youth make the connection between trauma-associated affects and high-risk situations.

## *CONCLUSIONS AND LIMITATIONS*

Trauma treatment for juvenile offenders is in its nascent stage. This paper describes trauma treatment groups based on education, self-paced controlled exposure and skill development, through the use of cognitive-behavioral and expressive arts techniques, that were provided to juvenile offenders in residential placement. The groups were an initial attempt to address trauma related issues in over 20 delinquent youth.

Group participants indicated that sharing their trauma experiences both directly and symbolically were the most important parts of the groups. Participants came to recognize the association between their trauma experience and their criminal acting-out, particularly their use of violence and substance abuse as coping mechanisms for the management of trauma-associated feelings. The youth that were familiar with the Relapse Prevention therapy found this approach helpful in assisting them to make a clear connection between trauma-associated sequelae and criminal behavior triggers.

The groups were heterogeneous both in terms of trauma history and degree of trauma exposure of members. Many juveniles experience

multiple and diverse traumas including sexual abuse, physical abuse, crime victimization, and community violence. It is unknown if it would have been beneficial to have youths in more homogeneous groups with respect to their type of trauma exposure (i.e., separate groups for those with sexual and physical victimization histories) or extent of exposure (i.e., separate groups for those with a few incidents of trauma exposure and those with hundreds of exposures).

All groups were conducted in highly controlled treatment environments where the members' behavior was monitored and clinical support was available. Many of the behaviors participants identified as problematic and associated to trauma (i.e. aggression and substance abuse) were environmentally controlled. It remains unclear how beneficial the groups were, particularly in relation to the expression of those behaviors in a less controlled environment. A longer study with a control group and community follow-up would be beneficial. Additionally, valid and reliable pre and post treatment measures should be integrated into any future study.

The first and third authors of the paper were treatment providers and the fourth author was an ongoing consultant to the treatment groups. The authors, due to their close association with the group, may have some reporting bias. It would be good to have independent evaluation of future treatment groups.

We believe that self-paced, controlled exposure in a safe treatment environment is an important element that should be considered as part of the treatment plan for juvenile offenders with histories of trauma exposure. We intend to expand this pilot program through further feedback-based refinements and the inclusion of treatment evaluation measures.

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